ILLINOIS BONE and JOINT INSTITUTE, LLC

Name: _____ */ MR#*_____

Today's Date: _____

MEDICAL HISTORY FORM

Last IBJI Visit Date: _____

PATIENT INFORMATION

_____
Name (First) (Last) (Middle)

Age: _____ Date of Birth _____ Sex: ☐ M ☐ F

Height: _____ Weight: _____ lbs ☐ Rt or ☐ Lt Handed

Occupation _____

REFERRING PHYSICIAN

_____
Name

_____
Street Suite

_____
City State Zip Code

_____
Phone

Working now? ☐ yes ☐ no ☐ disabled ☐ retired If retired, what was your previous occupation: _____

PREFERRED PHARMACY

Pharmacy: _____

Address: _____

Phone: _____

PRIMARY CARE PHYSICIAN (if different than above)

Name: _____

Address: _____

Phone: _____

HISTORY OF PRESENT ILLNESS

Reason for today's visit: _____

* If your visit is related to an injury, circle the appropriate response in the box below. If it is not related to an injury, skip this box.

The injury is due to: car accident / work injury / sports injury / fall / other _____
The injury occurred at: home / work / school / other _____
Are you off work due to the injury? yes / no If yes, last day worked_____ If no, any restrictions _____
Is legal action / litigation pending due to this injury? yes / no

DATE of onset / injury_____/_____/_____ **SYMPTOMS**_____

LOCATION of symptoms: _____ ☐ right ☐ left ☐ both ☐ NA

Circle each characteristic that best describes your problem:

QUALITY: Sharp / Dull / Throbbing / Aching / Burning / Cramping

SEVERITY: Mild / Moderate / Severe

DURATION: Infrequent / Intermittent / Constant / Hourly / Daily / Weekly

TIMING: During Activity / After Activity / Walking / Running / Stairs / Squatting / Pivoting / Overhead use / Throw / Lift / Other

CONTEXT: Improving / Worsening / Recurrent / More Frequent / Less Frequent / Unchanged

SYMPTOM RELIEF: Rest / Heat / Cold / Elevation / Physical Therapy / Brace / Injection / Medication / Other:_____

SYMPTOM AGGRAVATION: Activity / Position Change / Repetitive Motion / Fatigue / Other:_____

ASSOCIATED SYMPTOMS: _____

TREATMENT Describe treatment and response for current problem _____

_____

Have you had a problem with this area before? ☐ yes ☐ no If yes, describe problem and prior treatment: _____

_____

Have you had any diagnostic tests for this problem? ☐ yes ☐ no If yes, what and where? _____

_____

Do you have a copy of the test results? ☐ yes ☐ no Did you bring them with you? ☐ yes ☐ no

Has a physician recommended that you have surgery for this problem? ☐ yes ☐ no

Name of previous treating physician(s), if any: _____

Have you had any of the following services this year (check all that apply):

Physical Therapy ☐ Occupational Therapy ☐ Chiropractic Services ☐ Home Health Services ☐

ILLINOIS BONE and JOINT INSTITUTE, LLC

Name: _____ / MR#_____

REVIEW of SYSTEMS:

Have you ever experienced or do you currently have any of the following signs or symptoms? If "Yes", please describe:

SYMPTOMS	Yes	No	Describe all "Yes" responses
Eyes (e.g. blurred vision, double vision, loss of vision)			
Ears, Nose, Throat (e.g. sore throat, earache, ringing)			
Cardiovascular (e.g. chest pain, palpitations, ankle swelling)			
Respiratory (e.g. shortness of breath, cough, snore)			
Gastrointestinal (e.g. ulcer, gastritis, GI bleed, jaundice)			
Genitourinary (e.g. burning, bleeding or difficulty urinating)			
Musculoskeletal (e.g. joint, muscle, back or neck pain)			
Skin (e.g. delayed healing, rash, acne, cellulitis, psoriasis)			
Neurological (e.g. numbness, tingling, weakness)			
Mental Health (e.g. depression, anxiety, memory loss)			
Endocrine (e.g. weight gain/loss, excess thirst or urination)			
Hematologic (e.g. bruising, bleeding or clotting disorder)			
Allergic / Immunologic (e.g. rash, swelling, wheezing)			

PAST MEDICAL and FAMILY HISTORY:

Have you or a family member had problems with any of the following? Please indicate "Yes" with an "x".

DISEASE / CONDITION	Self	Father	Mother	Sibling	Child	Grand parent
Abnormal Heart Rhythm						
AIDS						
Anemia						
Angina						
Arthritis						
Asthma						
Bleeding Disorder						
BPH (benign prostatic hyperplasia)						
Cancer						
Cardiomyopathy						
Clotting Disorder						
Colitis						
COPD						
Diabetes Mellitus						
Eczema						
Emphysema						
Endocrine Problem						
Gall Bladder Disease						
GERD						
Heart Valve Problem						

DISEASE / CONDITION	Self	Father	Mother	Sibling	Child	Grand parent
Hepatitis						
High Blood Pressure						
High Cholesterol						
HIV						
Kidney Failure						
Kidney Stones						
Liver Problem						
Mental Disorder						
MI (myocardial infarction)						
Osteoporosis						
Psoriasis						
Psychiatric Problem						
Seizures						
Sickle Cell Anemia						
Stroke						
Thyroid						
TIA (transient ischemic attack)						
Tuberculosis						
Ulcer						
Urinary Tract Infection						
Other						

ILLINOIS BONE and JOINT INSTITUTE, LLC

Name: _____ */ MR#*_____

PAST SURGICAL HISTORY:

Procedure: _____ Surgeon _____ Date _____

Procedure: _____ Surgeon _____ Date _____

Procedure: _____ Surgeon _____ Date _____

SURGICAL COMPLICATIONS: _____

ANESTHESIA: Have you ever had **problems with anesthesia**? ☐ yes ☐ no If yes, please describe:_____

BLOOD: Have you ever had a blood transfusion? ☐yes ☐no Do you have a history of blood clotting? ☐yes ☐no

SLEEP APNEA: Do you have Sleep Apnea? ☐yes ☐no Snore? ☐yes ☐no Stop breathing during sleep? ☐yes ☐no

FOR MALE AND FEMALES AGED 65+:

Have you had 2 or more falls in the past year or any fall with injury in the past year? ☐yes ☐no

Are you currently taking a Vitamin D supplement? ☐yes ☐no

Have you had a Dexa/Bone Density Study done in the past 5 years? ☐yes ☐no

If yes, were you told you have osteoporosis? ☐yes ☐no

If yes, are you taking prescription medication for osteoporosis? ☐yes ☐no

MEDICATIONS (Prescription / Nonprescription / Herbal supplements / Vitamins / Other)**:**

Medication	**Dosage**	**Frequency**	**Route of Administration**

ALLERGIES: Please list type of allergy (medications, latex, food, metals, etc.) and type of reaction you experience: _____

SOCIAL HISTORY:

Student ☐ yes ☐ no School _____ Grade _____ Sport _____

Tobacco use: Check all those that apply: ☐ Current every day smoker ☐ Current some day smoker **Year started smoking**_____

☐ Heavy tobacco smoker ☐ Light tobacco smoker

☐ Never smoker ☐Former smoker **Year Quit**_____

Alcohol use: ☐ never ☐ occasional ☐ daily ☐ heavy History of alcoholism? ☐ yes ☐ no History of drug use? ☐ yes ☐ no

Marital status: ☐ single ☐ married ☐ divorced ☐ widowed

Do you live alone? ☐ yes ☐ no If no, who do you live with? _____

Are you residing in a skilled nursing facility (SNF) either temporarily or permanently? ☐ yes ☐ no

Are you pregnant? ☐ yes ☐ no Breastfeeding? ☐ yes ☐ no Date of last menstrual period: _____

Comments or Clarification:_____

Patient/Guardian Statement:

To the best of my knowledge, the above information is accurate and complete.

_____ ___/___/___
Patient Signature Date

_____ ___/___/___
Guardian Signature Date

_____
Guardian/Authorized Representative Printed Name

Provider Statement:

I have reviewed the questionnaire with the patient.
Any Changes

☐ yes ☐ no _____ ___/___/___
Signed Date